

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 13 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar No.

12708

45892

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips Hosp.				Length of stay in lb		d. STREET ADDRESS 2350 Biddle St.	
3. NAME OF DECEASED (Type or print) First Minnie Middle Harris Last				4. DATE OF DEATH Month 12-30-57 Day 57 Year			
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown Abt. 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Columbus, Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alfred Dodson				14. MOTHER'S MAIDEN NAME Nellie Clayton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Bishop Dodson-2350 Biddle	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Apoplexy</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <i>334x</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <i>8:15 A. M.</i> of the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deputy Registrar) <i>John M. Luman</i>			22b. ADDRESS <i>1300 Clark</i>			22c. DATE SIGNED <i>1/2/58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>1-3-58</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Washington Park Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Berkeley, Mo.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>A.L. Beal Und. Co.-4303 Delmar</i>				25. DATE RECD. BY LOCAL REG. <i>JAN 2 '58</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith Mo</i>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed

A. D. Richardson

Licensed Embalmer No. *290*

P. O. Address *2625 G*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.